**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

HYDE PARK SURGERY CENTER
4611 GUADALUPE ST STE 100
AUSTIN, TX 78751

**Respondent Name**
AMERICAN ZURICH INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-11-4084-01

**MFDR Date Received**
JULY 12, 2011

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Our position stands that timely filing does not apply because the patient neglected to provide the workers compensation information or even inform our facility that this would be filed as a worker compensation claim."

**Amount in Dispute:** $101,929.10

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "First of all, this dispute involves the date of service 2/8/10. The MR-100 indicates that the postmark date in which the dispute was received from Requestor was 7/12/11. Pursuant to DWC Rule 133.307(c)(1), requests for medical fee dispute resolution must be filed within one year of the date of service unless there are issues of compensability, extent of injury, liability, or medical necessity. There are no issues of compensability, extent of injury, liability, or medical necessity surrounding this date of service and should be immediately dismissed. "

**Response Submitted by:** Downs Stanford, P.C., 2001 Bryan Street, Ste 4000, Dallas, TX 75201

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 8, 2010 | 64493-RT, 64493-LT, 64494-RT, 64494-LT, 64495-RT, 64495-LT | $101,929.10 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 1, 2011
   - 29 – The time limit for filing has expired.

- 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

**Issues**

1. Did the requestor waive its right to medical fee dispute resolution?

**Findings.**

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is February 8, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 12, 2011. The requestor did not timely file with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

**Conclusion**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 02/20/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |
| | | 02/20/2013 |
| Signature | Director of Health Care Business Management | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.